Team Select
HOME CARE

2024-2025

Employee Benefits Guide

DECEMBER 1, 2024 – NOVEMBER 30, 2025

MEDICAL | DENTAL | VISION | LIFE | FSA'S AND MORE

Team Select HOME CARE

Each day, every member of **Team Select Home Care** plays a vital role in bringing our mission and core values to life. It is with sincere pleasure that we acknowledge your invaluable contributions by offering a comprehensive benefits package for you and your loved ones.

We invite you to review the benefits information provided in this guide. Our benefit plans serve as just one of the number of ways we can show our care for you and your family.

Inside the Guide

Important Contacts

Our benefit contacts and carrier partners work closely with Human Resources to make sure your benefit needs are taken care of quickly and completely. If you have questions or need more information about your benefits, reach out to the appropriate contacts listed below.

If you have questions, please contact:

Team Select Benefits Team
(602) 603-0495; benefits@tshc.com

Benefit	Carrier	Phone	Website
Medical	Lucent Health Group #100579	(888) 690-1787	www.lucenthealth.com/members
Claims Support, Provider Search, etc.	Narus Health Concierge	(800) 585-3309	www.narushealth.com/concierge
Prescription	Navitus	(844) 268-9789	www.navitus.com
Virtual Care	98point6	(866) 657-7991	www.98point6.com
Health Savings Account (HSA)	Pinnacle Bank	(888) 282-2605	www.pnfp.com/hblogin
Flexible Spending Account (FSA)	Pinnacle Bank	(888) 282-2605	www.pnfp.com/hblogin
Dental	Metlife Group #235398	(800) 942-0854	www.metlife.com
Vision	VSP Group #30095638	(800) 877-7195	www.vsp.com
Life and AD&D	New York Life	(800) 362-4462	www.mynylgbs.com
Disability	New York Life	(800) 362-4462	www.mynylgbs.com
Accident, Critical Illness, and Hospital Indemnity	Atlantic American	Questions: (866) 458-7502 Claims: (866) 458-7499	www.mynylgbs.com
Will Prep/Estate Planning and Identity Theft Employee Assistance Plan (EAP)	New York Life	(800) 344-9752	www.guidanceresources.com WEB ID: NYLGBS When registering, you will be asked to provide the first 5-characters of the company name. Please type "TEAM " (with a space included).
Pet Insurance	ASPCA	(877) 343-5314	www.aspcapetinsurance.com/teamselect

FULL-TIME EMPLOYEES

Eligibility & Mid-Year Changes

Benefits Eligibility

All full-time employees who work at least 30 hours per week are eligible to participate in our benefit plans. Eligible participants include employee, spouse, domestic partner (affidavit required), and dependent children up to age 26.

- The coverage you elect during Open Enrollment begins **December 1, 2024.**
- As a new hire, coverage begins after you satisfy the new hire **waiting period.**
- Coverage ends if you no longer meet eligibility requirements, contributions are discontinued, or the Group Insurance Policy is terminated.

Changing Your Benefits Outside Of Open Enrollment

The benefits you elect during the **2024-2025** benefits plan year will remain in effect through **November 30, 2025.** You cannot make changes to the benefits you elect until the next open enrollment period unless you have a qualifying event. The Health Insurance Portability And Accountability Act of 1996 (HIPAA) provides employees additional opportunities to enroll in a group health plan if they experience a loss of other coverage or certain life events. If you are declining coverage at this time for either yourself or your eligible dependents, you may be able to enroll yourself and/or your eligible dependents in coverage at a later date, if there is a loss of other coverage. You have the right to elect coverage during the plan year if your or your dependent's Medicaid/Children's Health Insurance Program (CHIP) coverage terminates due to discontinuation of eligibility under the program or if you become eligible for a Medicaid/CHIP premium assistance subsidy (if available in your state) providing you request enrollment within 60 days of the loss of coverage or eligibility for premium subsidy.

Qualifying Life Events

A qualifying event is a personal event that may require you to either add or remove coverage for yourself and/or your dependents.

Qualifying Life Events include:

- Marriage, divorce, or legal separation
- Birth or adoption of a dependent child
- Death of a dependent spouse or child
- Gain or loss of coverage for you or your eligible dependents
- Reaching age 26 for dependent children

Important Deadline For Qualifying Event Changes

You must make any coverage change within 30 days of the qualifying event. Report this change to Human Resources, with as much information as you have, within the **30-day** deadline, except for a Medicare or Medicaid entitlement event, in which case you must make changes within 60 days of the event.

You must include documentation to substantiate your qualifying event. If you miss the deadline, or do not provide the supporting documentation, changes will not be approved. Please contact Human Resources within **30 days** if you have any questions or believe that you may qualify for an election change.

Note: In the event that you miss the 30-day deadline to report a qualifying event, Team Select is unable to retroactively make changes to the enrollment due to IRS tax regulations (including any monthly costs which the employee may have incurred).

Reviewing and Updating Your Beneficiaries

Regularly updating beneficiary designations for financial accounts like life insurance and retirement plans is crucial to ensuring assets go to intended recipients.

There are primary beneficiaries, who receive assets and benefits first, and contingent beneficiaries, who receive them if the primary beneficiaries are unavailable.

To avoid common errors, update beneficiary designations after significant life changes, such as marriage, divorce, death of a spouse or child, birth of a child or similar event that alters your family. You should also update your beneficiary listing if a beneficiary changes their name (e.g. marriage).

Seek guidance from your HR department if you are unsure of how to make changes to your beneficiaries.

Terms and Definitions

Before reviewing our benefits, take a look at some terms that may be helpful in understanding and comparing the plans offered to you. By learning a few key insurance terms, you'll be more informed and better able to understand what, exactly, goes into your insurance coverage.

Deductible: The amount of healthcare costs you have to pay for with your own money before your plan will start to pay anything.

Embedded Deductible: An embedded deductible assigns a separate deductible to each covered individual within a family, with benefits applied after the individual deductible is met. This may or may not apply to your plans.

Shared Deductible: A shared deductible combines individual deductibles within a family, requiring the total expenses for covered services to reach a combined threshold (the family deductible) before insurance coverage begins. This may or may not apply to your plans.

Coinsurance: After the deductible (if applicable), you and the plan share the cost. For example, if the plan pays 80%, your coinsurance share of the cost is 20%. You are billed for your coinsurance after your visit.

Copay: A set fee you pay instead of coinsurance for some healthcare services, i.e. a doctor's office visit. You pay the copay at the time you receive care.

Out-of-Pocket Maximum: Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most eligible expenses for the rest of the plan year.

In and Out-of-Network: In-network services will always be the lowest cost option. Out-of-network services will cost more or may not be covered.

Balance Billing: In-network providers are not allowed to bill more than the plan's allowable charge, but out-of-network providers are. For example, if the provider fee is $100 but the plan allows only $70, an out-of-network provider may bill YOU the extra $30. This is called balance billing.

Save with Value-Based Pricing

We're always working to ensure providers are charging a fair price for medical procedures. That's why we utilize Value-Based Pricing (VBP) plans, designed to take care of members while reducing out-of-pocket costs.

What is Value-Based Pricing?

Unlike the PPOs, HMOs, and other plans you may be familiar with, VBP is designed to lower medical costs for you and DSG. Value-based pricing is a transparent way of determining how much hospitals will be paid for certain services.

With VBP, the health plan sets a maximum price it pays for certain medical procedures (the "reference price"). The reference price is based on the amount Medicare pays for the same procedures plus a percentage. The maximums are set with location in mind, so they differ based on where you live.

Sample Procedure	Traditional Health Plan	Our VBP Plan for 2025
STARTING PRICE	$75,000 (what the hospital *wants* to bill)	$15,000 (what Medicare would pay)
PLAN PRICE	$45,000 (hospital agrees to 60% of the bill)	$22,500 (hospital agrees to 150% of Medicare)
COINSURANCE	You pay 20%	You pay 20%
YOUR BILL	$9,000**	**$4,500****

**You pay the listed deductible and coinsurance, up to the annual out-of-pocket maximum.

Hospital Care & Emergency Care

Value-based pricing is a transparent way of determining how much hospitals will be paid for certain services, such as procedures. It works by reimbursing hospitals based on a reference price: *Medicare* (plus a percentage). Because it is fully transparent and based on costs, the end result is a price that is fair to both the hospital and the patient. Value-based pricing provides open access to facilities with no network restriction.

PRE-CERTIFICATION IS REQUIRED: To receive maximum benefits, please call 5-10 days prior to ALL inpatient admissions and outpatient hospital services. In the event of a true life-threatening emergency, please visit the nearest hospital for your care. *Call within 48 hours after an emergency admission.* Prior notification is recommended for pregnancy admissions. The facility is advised during the pre-certification process of the price allowed by the plan. You will be responsible for your deductible/coinsurance.

Please call (877) 499-1774 or visit www.lucenthealth.com/precert. Pre-certification is not a guarantee of benefits or payment.

In some cases, you may be advised that a facility other than the one recommended by your physician would provide a better benefit under the plan. If possible, it is better to go with a facility that works well with the plan. If you have any questions regarding which facility to use, please contact the **Narus Concierge** at (888) 585-3309 for assistance.

Value-Based Pricing: Q&A

How Do I Find a Facility?

Your physician will normally recommend a facility for the procedure. Your treatment will be pre-certified based on the plan guidelines. The price the plan will allow for the procedure is based off the rates established by Medicare. The facility is advised during the pre-certification process of the price allowed by the plan. You will be responsible for your deductible/coinsurance.

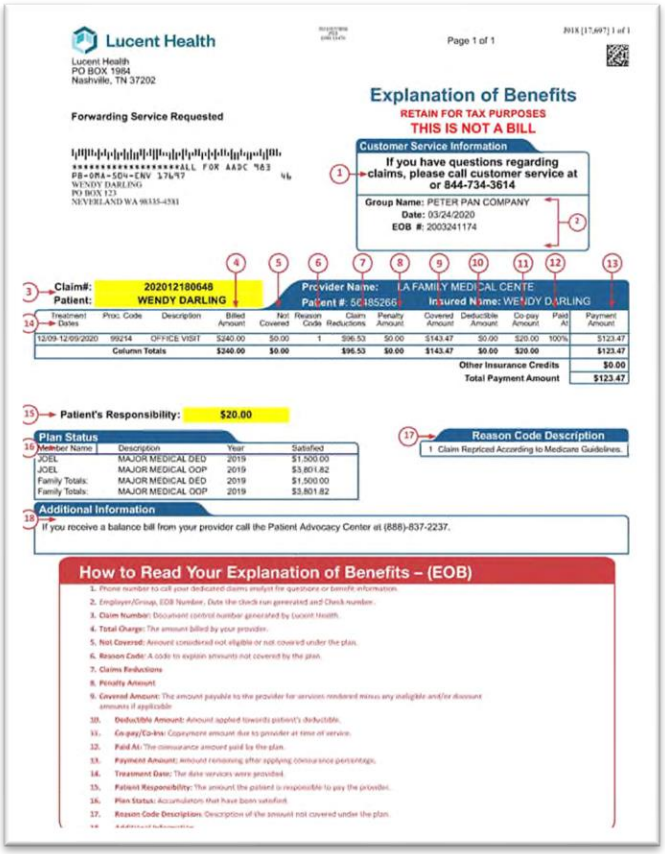
In some cases, you may be advised that a facility other than the one recommended by your physician would provide a better benefit under the plan. If possible, it is better to go with a facility that works well with the plan. If you have any questions regarding which facility to use, please contact the Brown & Brown Concierge for assistance.

What Happens When I Receive a Bill?

How do I know that my bill is correct? When you receive a bill from the facility, ALWAYS compare it to the Explanation of Benefits (EOB) from Lucent Health. If the amount on the bill does not match the EOB, you are being balance billed.

What should I do if I receive a balance bill? If a billed amount does not correspond directly with the amount reflected on your EOB, contact Narus Health immediately at (888) 585-3309! You will never be responsible for more than your plan's out of pocket maximum.

Your EOB looks like this:



Lucent Health

Lucent Health
PO BOX 1984
Nashville, TN 37202

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Forwarding Service Requested

WENDY DARLING
PO BOX 123
NEVERLAND WA 98335-4581

Explanation of Benefits

RETAIN FOR TAX PURPOSES
THIS IS NOT A BILL

Customer Service Information
If you have questions regarding claims, please call customer service at or 844-734-3614

Group Name: PETER PAN COMPANY
Date: 03/24/2020
EOB #: 2003241174

Claim#: 202012180648
Patient: WENDY DARLING

Provider Name: LA FAMILY MEDICAL CENTE
Patient #: 5C185266
Insured Name: WENDY DARLING

Treatment Dates	Proc. Code	Description	Billed Amount	Not Covered	Reason Code	Claim Reductions	Penalty Amount	Covered Amount	Deductible Amount	Co-pay Amount	Paid At	Payment Amount
12/09-12/09/2020	99214	OFFICE VISIT	$240.00	$0.00	1	$96.53	$0.00	$143.47	$0.00	$20.00	100%	$123.47
		Column Totals	$240.00	$0.00		$96.53	$0.00	$143.47	$0.00	$20.00		$123.47

Other Insurance Credits $0.00
Total Payment Amount $123.47

Patient's Responsibility: $20.00

Plan Status

Member Name	Description	Year	Satisfied
JOEL	MAJOR MEDICAL DED	2019	$1,500.00
JOEL	MAJOR MEDICAL OOP	2019	$3,801.82
Family Totals:	MAJOR MEDICAL DED	2019	$1,500.00
Family Totals:	MAJOR MEDICAL OOP	2019	$3,801.82

Reason Code Description
1 Claim Repriced According to Medicare Guidelines.

Additional Information
If you receive a balance bill from your provider call the Patient Advocacy Center at (888)-837-2237.

How to Read Your Explanation of Benefits – (EOB)

1. Phone number to call your dedicated claims analyst for questions or benefit information.
2. Employer/Group, EOB Number, Date the check was generated and Check number.
3. **Claim Number:** Document control number generated by Lucent Health.
4. **Total Charge:** The amount billed by your provider.
5. **Not Covered:** Amount considered not eligible or not covered under the plan.
6. **Reason Code:** A code to explain amounts not covered by the plan.
7. **Claims Reductions**
8. **Penalty Amount**
9. **Covered Amount:** The amount payable to the provider for services rendered minus any ineligible and/or discount amounts if applicable.
10. **Deductible Amount:** Amount applied towards patient's deductible.
11. **Co-pay/Co-Ins:** Copayment amount due to provider at time of service.
12. **Paid At:** The coinsurance amount paid by the plan.
13. **Payment Amount:** Amount remaining after applying coinsurance percentage.
14. **Treatment Date:** The date services were provided.
15. **Patient Responsibility:** The amount the patient is responsible to pay the provider.
16. **Plan Status:** Accumulators that have been satisfied.
17. **Reason Code Description:** Description of the amount not covered under the plan.

Medical

Our medical plan benefits are provided through **Lucent Health** through your choice of the **PHCS Network** or the **Cigna Choice Fund PPO Network.** The table below outlines how some of the most common services are paid when using our medical plans. While the PHCS network is *open access, meaning that all claims are paid at the "in-network" level no more where you go for care*, the Cigna Choice Fund PPO Network does have in and out-of-network benefits. You will pay less for care when you see an in-network physician.

Medical Benefits	$5,000 Copay Plan	$1,000 Copay Plan	HDHP HSA Plan
Networks	**PHCS or Cigna Choice Fund PPO**		
Plan Year Individual Deductible	$5,000	$1,000	$5,000
Plan Year Family Deductible	$10,000 Embedded	$2,000 Embedded	$10,000 Embedded
Plan Year Individual Out-of-Pocket Maximum	$9,450	$9,450	$8,050
Plan Year Family Out-of-Pocket Maximum	$18,900	$18,900	$16,100
Your Coinsurance Share	20% *After Deductible (**AD**)*	20% *After Deductible (**AD**)*	20% *After Deductible (**AD**)*
Qualified Health Savings Account	No	No	**Yes**
Preventive Care	**Covered at 100%**		
PCP Office Visit	$20 Copay	$20 Copay	You Pay 20% ***AD***
Specialty Office Visit	$40 Copay	$40 Copay	You Pay 20% ***AD***
MDLive Virtual Visits	Amount Paid Varies	Amount Paid Varies	You Pay 20% ***AD***
Urgent Care	$75 Copay	$75 Copay	You Pay 20% ***AD***
Emergency Room	You Pay $500 Copay	You Pay $500 Copay	You Pay 20% ***AD***
Inpatient Hospital Services	You Pay 20% ***AD***	You Pay 20% ***AD***	You Pay 20% ***AD***
Outpatient Diagnostic X-Ray & Lab Services	You Pay 20% ***AD***	You Pay 20% ***AD***	You Pay 20% ***AD***
Major Lab – MRI, PET/CAT Scans	$500 Copay	$500 Copay	You Pay 20% ***AD***
Prescription Drugs (30-Day Supply; CVS Pharmacy is excluded from in-network pharmacies)			
Tier 1 Generic	$15 Copay	$15 Copay	$15 Copay ***AD***
Tier 2 Preferred Brand	$30 Copay	$30 Copay	$30 Copay ***AD***
Tier 3 Non-Preferred Brand	$60 Copay	$60 Copay	$60 Copay ***AD***
Tier 4 Specialty	You Pay 25% Up to $500	You Pay 25% Up to $500	25% Up to $500 ***AD***
Rx Mail Order (90-Day Supply)	2.5x Retail Copay	2.5x Retail Copay	2.5x Retail Copay ***AD***

Please refer to your plan documents for full details and exclusions.

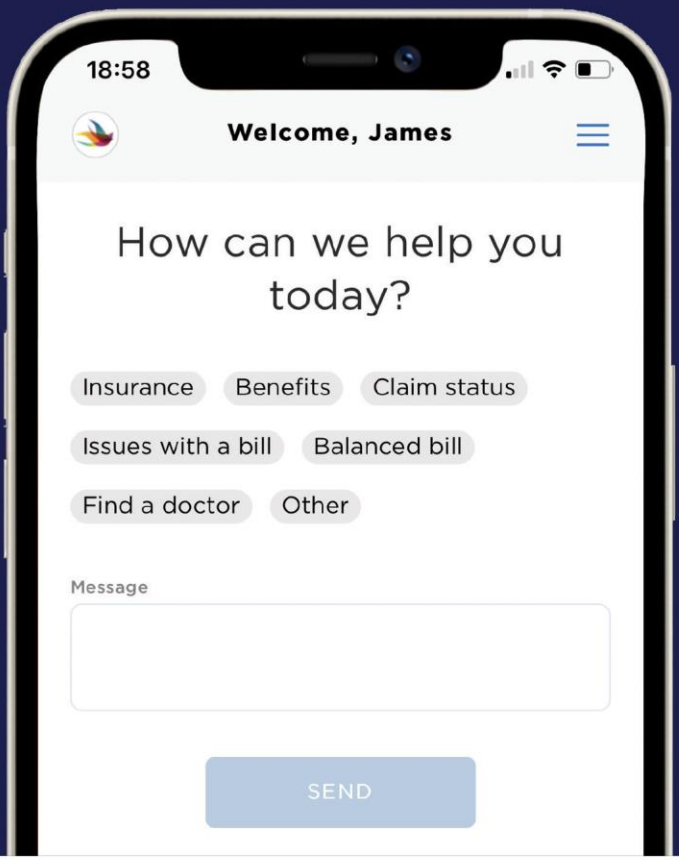
Medical Network Comparison

Need help finding a provider or facility to utilize? Contact **Narus Health at (888) 585-3309.**

Medical Plan Services	PHCS	Cigna Choice Fund PPO
How to Find a Provider	Visit https://portal.hstechnology.com/PHCS or call (888) 585-3309	Visit https://hcpdirectory.cigna.com/web/public/consumer/directory, login to your myCigna account, or call (888) 585-3309
Plan Administrator	Lucent	Lucent
Plan Options	Three medical plan options to choose from	Three medical plan options to choose from
In-Network Benefits	All providers and facilities are considered In-Network or Open Access	Choosing Cigna providers and contracted facilities will result in lower out-of-pocket expenses
Out-of-Network Benefits	N/A	You will have higher out-of-pocket expenses when choosing an out-of-network provider
Facility Charges	Potential for lower out-of-pocket expenses	Claims are paid and processed at Cigna provider pre-negotiated contracted amounts
Navitus Prescription Drug Programs	Same for PHCS and Cigna	Same for PHCS and Cigna
98.6 Virtual Visits	Available for all three medical plan options	Available for all three medical plan options
Narus Concierge Care Services	Available for all three medical plan options	Available for all three medical plan options
Patient Advocacy Center (PAC) with HST	Available for all three medical plan options	N/A – Claims are paid and processed at Cigna provider pre-negotiated contracted amounts
Lucent Health Member Portal	Available for all three medical plan options	Available for all three medical plan options
Medical Plan Contributions	Lower contributions per pay period	High contributions per pay period
Physician Network	PHCS for all states but Texas, Washington, and Indiana participants. For TX, WA, and IN: your physician network is the HealthSmart network.	PPO, Choice Fund PPO

Please refer to your plan documents for full details and exclusions.

Narus Health
YOUR LIFE. YOUR WAY.



Your Narus Health Concierge:
Call 888-585-3309

Members get a dedicated phone number and can talk to a care team member Monday–Friday from 7 a.m. to 7 p.m. CST and get direct help with various healthcare-related needs.

Members have access to the Narus Health Concierge Care team to:

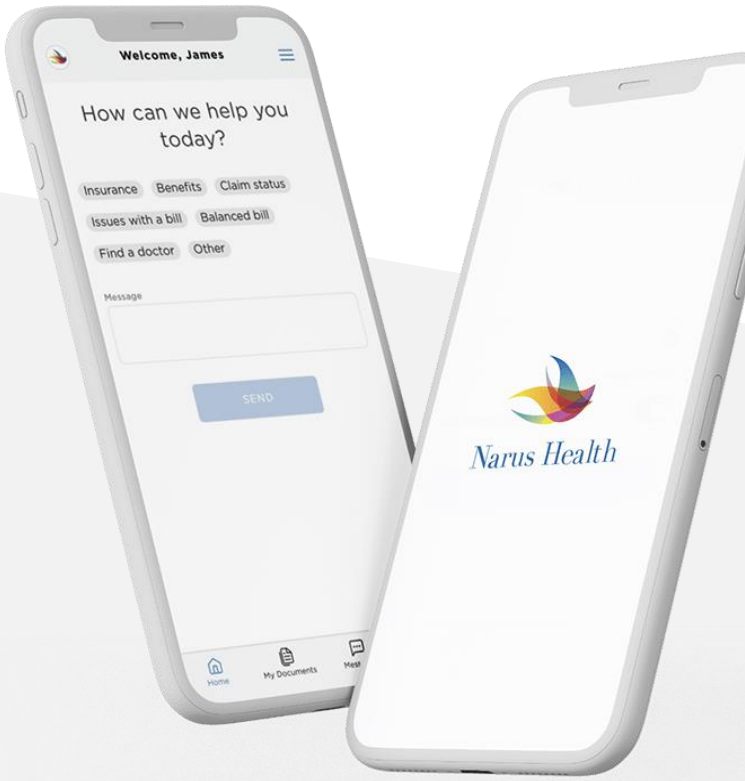
- Find a doctor or specialist
- Discuss a health concern
- Get help with a bill or explanation of benefits (EOB)
- Request a medication refill
- Ask questions about co-pays and claims
- Get assistance with various provider issues (e.g. list of network providers, scheduling appointments, providing VOB, nominate provider for network, etc.)
- Find a facility that will accept Lucent Health-contracted insurance benefits
- Navigate pre-certification issues
- Get support when a facility pushes back on accepting coverage
- Coordinate with Lucent Health resources to conduct payment at point of scheduling
- Request a new or replacement ID card

The Concierge Care Program is designed for direct member engagement—the Care Support Team is available to respond to plan member needs securely and confidentially, as they reach out via phone or mobile text messaging.

The Care Support Team also has direct access to internal Lucent Health resources to help resolve matters efficiently and effectively.

Concierge:
Member #: **888-585-3309**
Website: **www.narushealth.com/concierge**

Care at Your Fingertips



The Narus Health **MPOWER**™ app provides a simple and convenient way for you and your family to manage every aspect of your care.

By providing a better care experience, and securely enabling reporting of well-being, messaging, consolidated contacts and key phone numbers, the Narus Concierge is at your fingertips.

Secure Messaging

Encrypted, private messaging between you and the Narus Health Concierge and care team.

Organization of Important Data

Quickly access and download records, documents, and other facts that are important to your healthcare. The **MPOWER**™ app expands functionality based upon your enrollment in the program and the information you record.

Medical Contacts Made Easy

We create a list of important medical contacts for you. Help is never more than a click away.

Download on the App Store

GET IT ON GOOGLE PLAY

Lucent Health DATA DRIVEN + HUMAN FOCUSED | Narus Health A LUCENT HEALTH COMPANY

Questions? Reach out to the Narus Concierge directly at (888) 585-3309; concierge@narushealth.com

Lucent Health Member Portal

Whether you're facing a sudden health event or planning for an upcoming procedure or treatment, we're here for you. If you need care, have questions or are looking for resources, assistance is always just a click away on your Lucent Health Member Portal.

Have your ID card handy? Visit mylucenthealth.com and click Register Account. Accept the terms & Conditions and create a username and password to gain access to the portal!

Explore Your Coverage

Access detailed information about your health plan benefits and summaries. Understand the scope of your coverage and make informed decisions about your healthcare needs.

On-the-Go ID Access

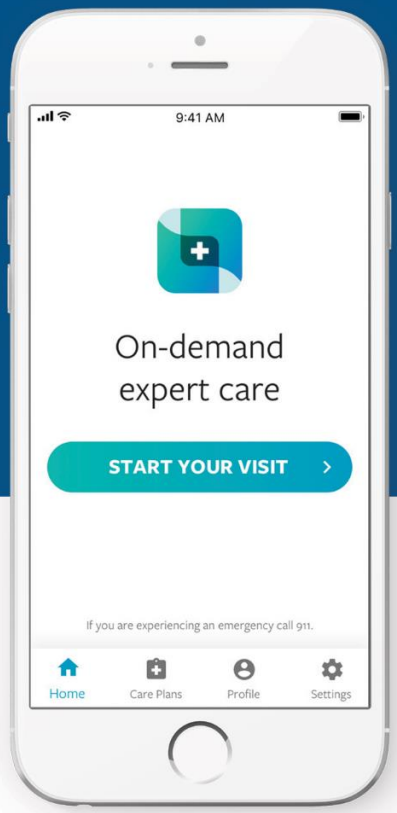
Print temporary ID cards instantly, ensuring you have quick and convenient access to your health insurance details whenever you need them.

Locate Trusted Providers

Easily find a healthcare provider that aligns with your preferences and needs.

Financial Clarity

Our portal provides a transparent overview of your financial responsibilities, helping you manage and plan for healthcare costs more effectively.



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While sick in bed


While on a break


At the baseball game


Enjoying the outdoors


While making dinner


While relaxing at home

No appointment, no waiting room, and no insurance claims.

www.98point6.com/members

98point6

Team Select HOME CARE

Health Savings Account

If you are enrolled in our **HDHP Plan** and have elected a Health Savings Account (HSA), your contributions are tax-exempt, meaning you save on both FICA and Federal taxes when contributing through payroll. Your HSA funds can be used to pay for unreimbursed medical, dental or vision expenses for you and your dependents, whether or not they are covered by your health plan. You can even use funds to pay for COBRA, long-term care, and Medicare (but not Medigap) premiums. Your HSA works like a personal bank account - no 'use-it or lose-it' rule. Funds remain in your account until needed, even if you change jobs or retire.

The HSA is not an automatic feature of enrolling in a HDHP; it is a separate application that you must make with **Pinnacle**. If you would like to set up direct deposit into your HSA, you must provide payroll with your HSA account and routing numbers. Similar to other direct deposits you may already have, you can increase, decrease, start or stop your HSA contributions throughout the year.

Who is eligible to open and fund an HSA?

Anyone who is:
- covered by a qualified HDHP (HSA OAP); and
- not covered under another medical plan that is not a qualified HDHP - including Medicare, Medicaid, TriCare, VA and/or a Health Care Flexible Spending Account (FSA), including a spouse's FSA.

How much can I contribute to an HSA?

The IRS sets a contribution limit every calendar year.

For 2024, the contribution limits are:
- $4,150 for Individual Coverage - just you on the plan
- $8,300 for Family Coverage - you and any number of dependents

For 2025, the contribution limits are:
- $4,300 for Individual Coverage - just you on the plan
- $8,550 for Family Coverage - you and any number of dependents

If you're age 55 or older, you can contribute up to $1,000 more than the limits listed here

What if I establish an HSA mid-year?

Your HSA contributions are generally determined on a monthly basis. If you establish an HSA mid-year, you're allowed to make the full year's contribution, provided you are eligible on December 1 of that year and you remain eligible to make HSA contributions throughout the next calendar year.

How do I make contributions to my HSA? You can contribute to your HSA through payroll deductions.

Where can I find a list of qualified expenses? Refer to the list found at irs.gov - search Publication 502.

When can I start using the funds in my HSA?

You can use the funds in your HSA once they are available. You can reimburse yourself for qualified HDHP expenses months or even years later if you retained receipts and your HSA was established when the expense occurred.

Can I use my HSA to pay for non-qualified expenses? Non-qualified expense withdrawals are subject to income tax and a 20% penalty until age 65. After age 65, non-qualified expense withdrawals are penalty-free, but remain subject to income tax.

What happens to my HSA if I leave my employer? The HSA is yours to keep. If you continue to meet the eligibility criteria for funding the account, you can continue making contributions to your HSA. If you are no longer eligible to fund the account, you're still eligible to spend the money (tax-free) on qualified expenses.

Can I use the money in my HSA to pay for my dependents' health care expenses?

You can use the money in your HSA to pay for the health care expenses belonging to your eligible spouse and/or dependent children - even if they are not covered as your dependents. Refer to Internal Revenue Code Section 152 to determine if your spouse and/or child is an eligible dependent.

Can couples establish a "joint" HSA and both make contributions, including "catch-up" Contributions?

"Joint" HSAs are not permitted. Each spouse should consider establishing an HSA in his or her own name. This allows you to both make catch-up contributions when you are age 55 or older.

Flexible Spending Account

You have the opportunity to pay for out-of-pocket medical, dental, vision, and/or dependent care expenses with pre-tax dollars through a Flexible Spending Account (FSA) through **Pinnacle.**

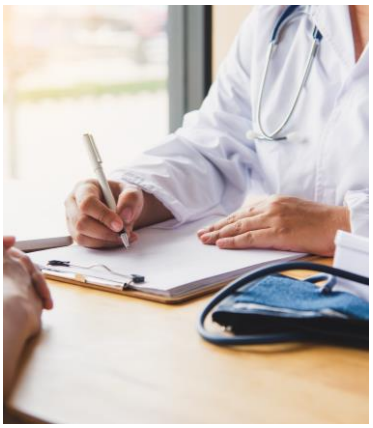
Contributions to your FSA come out of your paycheck before any taxes are taken out. This means that you don't pay federal income or FICA taxes on the portion of your paycheck you contribute to your FSA.

You should contribute the amount of money you expect to pay out-of-pocket for eligible expenses incurred during the Plan Year. If you still have money in the account at the end of the Plan Year (**December 31, 2025**), you will have a 3-month extension period to turn in additional eligible expenses from the prior Plan Year. Any money remaining in the account when the extension period ends is forfeited; this is the "use-it or lose-it" rule.

Do your homework and consider known expenses. Make an informed decision when you elect your contribution for the year. FSA elections can only be changed during Open Enrollment or due to a Qualifying Event.

IMPORTANT NOTE: If you will be funding an HSA, you cannot participate in the Health Care FSA. Per IRS guidelines, FSA contributions must be elected every year.

Plan Year: December 1, 2025 – November 30, 2025
2024 Healthcare Flexible Spending Account Annual Contribution Limit: $3,200
2024 Dependent Care Annual Contribution Limit: $5,000



Health Care FSA

A Health Care FSA is used to reimburse out-of-pocket health care expenses incurred by you, your spouse and/or your children; whether you cover them or not. Eligible expenses include deductibles, coinsurance, copays, etc. Your Health Care contributions are pre-loaded to a debit card; you have immediate access to the funds and will pay them back throughout the year via payroll deduction.

Dependent Care FSA

A Dependent Care FSA is used to reimburse work related expenses while you or your spouse work, look for work or attend school full-time and are physically unable to care for your dependent. Eligible expenses cover care for children under 13 or dependents unable to care for themselves. This includes daycare, preschool, and before/after school programs. Funds are payroll deducted and are not pre-loaded onto a debit card.

Health & Wellbeing Resources

It's important to know what benefits you have when a question comes up. Whether it's finding free counseling or managing your finances, help is available through your Team Select Home Care health and well-being benefits as well as several national resources.

FindHelp.org

On www.findhelp.org, you can search for and connect to support for reduced cost help related to food, housing, goods, transit, health, money, care, education and legal needs based on your zip code

988Lifeline.org

Need Immediate Help in a Crisis? Whether you're facing mental health struggles, emotional distress, alcohol or drug use concerns, or just need someone to talk to, our caring counselors are here for you. You are not alone. Dial 988 or visit the 988 Suicide & Crisis Lifeline online at www.988lifeline.org.

NAMI

NAMI is the National Alliance on Mental Illness, the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. If you or someone you know needs help (depression, anxiety, stress, PTSD, grief, domestic abuse, substance abuse, sexual assault, etc., call the NAMI helpline at (800) 950-6264, email helpline@nami.org, or text 62640.

Confidential Employee Assistance Plan

The Employee Assistance Plan (EAP) can assist you during challenging times when you need a little extra help. Whether the issues are big or small, the EAP support program is available to help you and your family find a solution to restore peace of mind. All employees have free, confidential access to a program that offers support, guidance and resources.

- Child and senior care issues
- Relationships
- Workplace Conflicts
- Stress, anxiety and depression
- Life improvement and personal achievement
- Legal and financial consultation
- 100% CONFIDENTIAL

You and your household members have access to three face-to-face sessions with a behavioral counselor. Access New York Life's EAP Program 24 hours a day, 7 days a week by calling (800) 344-9752 or by going online at www.guidanceresources.com, using Web ID: NYLGBS.

Available to all employees and members of their household, including children up to age 26.

Voluntary Dental

Our dental plan benefits are provided through **MetLife's PDP Network**. The table below outlines how some of the most common services are paid at in-network and out-of-network providers and facilities. While you have the ability to see any dentist, you will pay less for care when you see an in-network physician.

As a voluntary benefit, you are responsible for the cost of this coverage through payroll deduction.

To find a dental provider: visit https://providers.online.metlife.com/findDentist or call (800) 942-0854 to speak with a Metlife representative.

Dental Benefits	High Plan		Low Plan	
	PDP Network	Out-of-Network	PDP Network	Out-of-Network
Deductible				
Individual	$50		$50	
Family	$150		$150	
Plan Year Maximum				
Plan Year Maximum	$1,500		$1,000	
Preventative Services	**Covered at 100%**			
Basic Services	You Pay 0% ***AD***	You Pay 20% ***AD***	You Pay 20% ***AD***	You Pay 50% ***AD***
Major Services	You Pay 40% ***AD***	You Pay 50% ***AD***	You Pay 70% ***AD***	You Pay 85% ***AD***
Orthodontia Services (up to age 19)	Covered at 50% Deductible does not apply		Not covered	
Orthodontia Lifetime Maximum	$1000		Not covered	
AD = After Deductible is Met				

Please refer to your plan documents for full details and exclusions.

Voluntary Vision

Our vision plan benefits are provided through the **VSP Vision Network**. The table below outlines how some of the most common services are paid at in-network providers and facilities. You will pay less for care when you see an in-network physician. As a voluntary benefit, you are responsible for the cost of this coverage through payroll deduction.

To find a vision provider: visit www.vsp.com/eye-doctor or call (800) 877-7195 to speak with a VSP representative.

Vision Benefits	VSP Vision Network	Frequency
Eye Exam	$10 copay	Once every 12 months
Standard Eyeglass Lenses		
Single Lenses	$25 copay	Once every 12 months
Lined Bifocal Lenses	$25 copay	Once every 12 months
Lined Trifocal Lenses	$25 copay	Once every 12 months
Lined Lenticular Lenses	$25 copay	Once every 12 months
Frames	$130 allowance + 20% discount on remaining balance;	Once every 24 months
Contact Lenses (in lieu of eyeglass lenses)		
Elective	$130 allowance	Once every 12 months
Extra Savings Contracted VSP Providers	• $70 Walmart/Costco frame allowance • Laser Vision Correction: Average 15% off retail price or 5% off promotional price. • Retinal Screening: no more than a $39 copay on routine retinal screening as an enhancement to a Well Vision Exam. • Glasses and Sunglasses. • Extra $20 to spend on featured frame brands. Go to vsp.com/offers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last Well Vision Exam. • Hearing Aid Discounts through TruHearing.	
Diabetic Eye Care Plus Program	Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.	

Please refer to your plan documents for full details and exclusions.

Voluntary Life & Accidental Death & Dismemberment

If you are a full-time eligible employee, Voluntary Life and AD&D is available for purchase through **Cigna**. When initially eligible, you are guaranteed the insurance amounts below without submitting any **Evidence of Insurability (EOI)** or answering health questions if you enroll within 31 days of your initial eligibility date. Any life insurance coverage over the Guarantee Issue Amount(s) will be subject to EOI. If required, it is your responsibility to complete and submit the required EOI forms within 31 days of the date you apply for coverage. If you elect Voluntary Life Insurance, your Voluntary AD&D benefit amount will be equal to your Voluntary Life Insurance election.

During your initial enrollment period, Cigna will issue up to the Guarantee Issue amount with NO medical information required. If you decide to add or increase your coverage up to the Guarantee Issue amount after your initial eligibility period, you will need to complete Evidence of Insurability (EOI). In this case, coverage will not be issued until the you receive written approval from Cigna.

Coverage is available for you and your dependent(s). You must elect coverage for yourself before electing coverage for dependents. Rates for this coverage can be found in your HRIS platform.

Coverage	Benefit Amounts	Guarantee Issue Applies to newly eligible only
Employee	$10,000 up to a maximum of $200,000	$200,000
Spouse	$5,000 increments not to exceed 50% of employee benefit or $100,000	$50,000 Not to exceed 50% of employee benefit
Children up to age 26	$10,000	$10,000

Voluntary Life and AD&D Insurance benefits reduce by 33% at age 70 and 55% at age 75.

Certain benefits might include active work requirements under which insurance coverage does not begin unless and until an employee is actively at work. Notwithstanding anything in the Benefit Guide to the contrary, all active work and/or active employment requirements applicable under a plan must be satisfied. Furthermore, insurance coverage for eligible dependents may be delayed if they are confined (at home, in a hospital, or in any other institution or facility) or disabled on the date insurance would otherwise begin, in accordance with the terms of the policy.

Conversion and portability options are available, please reach out to Human Resources for more information within 30 days of your exit.

Please refer to your plan documents for full details and exclusions.

Voluntary Short-Term & Long-Term Disability

We offer Short-Term Disability (STD) insurance and Long-Term Disability (LTD) insurance through **Cigna.** As voluntary benefits, you are responsible for paying the cost of this coverage through post-tax payroll deduction. Rates for these coverages are salary-based and can be found on your HRIS platform.

In the event you become disabled from a non-work-related injury or sickness, disability income benefits are provided as a source of income. You are not eligible to receive short-term disability benefits if you are receiving workers' compensation benefits.

Voluntary *Short-Term* Disability			
% of Income Replaced	Maximum Weekly Benefit	Benefit Waiting Period	Maximum Benefit Period
60% of weekly earnings while meeting the definition of disability	$1,000 per week	7 days	13 weeks
Pre-existing Condition Limitation	Any condition that you receive medical attention for in the 6 months prior to your effective date of coverage that results in a claim during the first 12 months of coverage, would not be covered.		

Voluntary *Long-Term* Disability			
% of Income Replaced	Maximum Weekly Benefit	Benefit Waiting Period	Maximum Benefit Period
60% of monthly earnings while meeting the definition of disability	$5,000 per month	90 days	Up to Social Security Normal Retirement Age
Pre-existing Condition Limitation	Any condition that you receive medical attention for in the 3 months prior to your effective date of coverage that results in a claim during the first 12 months of coverage, would not be covered.		

Benefit amounts may be reduced by other income such as sick leave and state disability income.

Certain benefits might include active work requirements under which insurance coverage does not begin unless and until an employee is actively at work. Notwithstanding anything in the Benefit Guide to the contrary, all active work and/or active employment requirements applicable under a plan must be satisfied.

Please refer to your plan documents for full details, other income reductions, and exclusions.

GROUP ACCIDENT INSURANCE

Expense-Based Coverage

Team Select HOME CARE

Value of Accident Insurance

- Pays a lump sum cash benefit for covered expenses due to accidental injuries
- Spouse and children coverage available
- Pays in addition to other insurance
- Affordable premiums, conveniently payroll deducted
- Benefits are portable, take it with you if you leave or change jobs

Help protect your family from the out-of-pocket costs of an accident

Atlantic American Employee Benefits' Accident insurance plan complements your group health insurance and covers unexpected expenses that result from all kinds of accidents, even sports-related and household ones.

Our simple-to-use, expense-based plan, has no schedule of benefits, and eligible services related to the original accident are covered, even if they're incurred on different days or with different providers. Think of it as "one bucket" of money you could use, to pay for deductibles and copays. It pays 100% of eligible services and supplies related to an accidental injury (unless covered by workers' compensation or similar law) up to the benefit limits.

$1,644

average deductible single coverage, up 79% over 10 years

https://bit.ly/3fTdmvV

How can Accident insurance help?

Medical expenses:

- Copayments
- Deductibles
- Other care you are financially responsible for under your medical plan

Non-medical expenses while recovering:

- Groceries
- Rent or mortgage
- Car payments
- Childcare

ATLANTIC AMERICAN Employee Benefits

AAEB GACP21 EEG 1209 AME TS (9-21)

How does Accident insurance work?

If you had an accident, your health insurance covers some costs, after you meet your deductible. But you still may have copays and a lot of out-of-pocket expenses. With Atlantic American Employee Benefits' Accident insurance, you can receive a cash payment when you have a covered accident or injury.

1 You have an accident & receive treatment

You accidently get injured, leading to more than one medical appointment, on different days, over the course of several weeks. Pretty soon you have several invoices, from more than one provider.

2 You receive a check from us

Before you even see what your health insurance will pay, you submit to us, copies of all your invoices. With approval, we pay you one check, for total billed charges, up to your annual benefit limit.

3 You get back out there

With our easy claims process, you're in receipt of money fast. Now you can pay provider balances, left by your health plan's deductibles, coinsurance and unpaid out-of-network charges.

What are the common charges associated with an accident?

- Urgent care
- X-ray
- Treatment for fractures, sprains, strains
- Physician office-follow-up visit
- Childcare while recovering

You are not alone when you have Atlantic American Employee Benefits' protection. Care is important. And so is your Atlantic American Employee Benefits' Accident insurance.

500,000

estimated number of children, under age 14, sustain playground injuries annually

https://bit.ly/3uSo5ep

Easy access to coverage and filing claims

MyCoverage is an easy-to-use website that allows you to access coverage and benefit information 24/7, file claims, update your profile and more.

mycoverage.atlam.com

AAEB GACP21 EEG 1209 AME TS (9-21)

GROUP CRITICAL ILLNESS INSURANCE

Cancer Coverage

Team Select HOME CARE

Value of Group Critical Illness with Cancer Coverage

- Cash benefits for a diagnosis of invasive and non-invasive cancers
- Affordable premiums paid through payroll deduction
- Coverage is guaranteed with no medical questions asked
- No restrictions on network or medical provider
- Benefits are portable, take it with you if you leave or change jobs

Protection that may help ease the financial, mental, and emotional burden that comes with cancer

Cancer can affect anyone — and treatment can be costly. While cancer survival rates are on the rise, out-of-pocket costs pose a substantial economic burden to patients and their families. In fact, the average out-of-pocket cost for a person battling cancer is estimated to be $2,598 a month[1] with cancer patients 2½ times more likely to declare bankruptcy than healthy people.[2] Even with the best medical plan, you can be left with unexpected costs. Deductibles, out-of-network treatments, home health care needs and travel are just some of the costs you could face if diagnosed with cancer, leaving you with reduced savings.

[1] https://bit.ly/3Ck4dGd
[2] https://bit.ly/2WZZ9GT

Benefits can help you pay for:

- Your medical plan's annual deductible
- Non-medical expenses resulting from treatment
- Alternative and experimental treatment
- Daily expenses, like food and utilities
- Contractor fees for home modifications, such as a wheelchair ramp

Age-based rates for this coverage can be found in your HRIS platform

ATLANTIC AMERICAN Employee Benefits

AAEB GCIP21 EEG 1210 CI-C TS (8-21)

How does Critical Illness with Cancer coverage work?

It's estimated that there will be approximately 1.9 million new cancer diagnoses in 2021 or 5,200 new cases per day.[3] With Atlantic American Employee Benefits' Critical Illness with Cancer coverage, you can help protect your finances if faced with an unexpected cancer diagnosis.

[3]https://bit.ly/2VAguoR

1 You're diagnosed with cancer

After you or a covered family member are diagnosed with cancer, you present the diagnosis to Atlantic American Employee Benefits for verification.

2 You receive a check from us

With approval of your claim, Atlantic American Employee Benefits pays you a cash benefit. With this added comfort of financial protection, you can seek medical care outside your medical plan's provider network or even seek experimental treatment.

3 You're looking forward to the future

After treatment, you'll need to recover and you may still need time off for follow-up appointments and checkups. With the cash benefits you can receive, you can feel empowered knowing you can transition back into work, replace lost wages, pay for daily expenses and rest a little easier.

How would you pay for expenses related to treating cancer?

In addition to treatment costs, there are typically many other related expenses to consider. Common charges associated with treating cancer:

- Transportation to medical appointments
- Travel and air for second opinion
- Lodging while receiving treatment
- Lost wages from reduced work schedules
- Caregiving costs for yourself or children

With cancer-related costs estimated to increase by 34% by 2030[4], purchasing this coverage may help provide the financial protection you need.

[4]https://bit.ly/3xqvCCO

40.5% MEN
38.9% WOMEN

Probability of being diagnosed with invasive cancer

https://bit.ly/3jlCAnw

GROUP HOSPITAL INDEMNITY INSURANCE

Team Select HOME CARE

Value of Hospital Indemnity Insurance

- Cash benefit for unplanned or uninsured expenses resulting from a hospitalization due to sickness or injury
- Premiums are convenient and paid through payroll deduction
- Coverage is guaranteed with no medical questions asked
- There are no deductibles, no copayments and no network restrictions
- Benefits are portable, take it with you if you leave or change jobs

Everyone deserves protection against hospital bills

Hospital stays can be pricey, and often unexpected. Even the best medical plans can leave you with extra expenses to pay or services that just aren't covered. Things like plan deductibles, copays, extra costs for out-of-network care, or non-covered services. Many people aren't prepared to handle these extra costs, so having this extra financial support when the time comes may mean less worry for you and your family.

16.2 MILLION

ER visits that become hospital admissions

https://bit.ly/2UfpFug

Benefits can help you pay for:

- Costs that are not covered by health plans
- Deductibles and copays left by major medical insurance
- Lost income while receiving care or replace a spouse's income while they're by your side
- Out-of-network costs for alternative treatment
- Travel for care and treatment, or even a second opinion
- Contractor or handyman to make changes to your home after an illness, such as a wheelchair ramp

ATLANTIC AMERICAN Employee Benefits

AAEB GHIP21 EEG 1211 HI TS (8-21)

GROUP HOSPITAL INDEMNITY INSURANCE

Coverage Details

Atlantic American Employee Benefits' Group Hospital Indemnity insurance plan includes the benefits listed below. Each benefit is subject to conditions for payment as detailed in the certificate.

$4,500
average cost of giving birth even with insurance

https://bit.ly/3661LnQ

Plan Information

Available To	Employee/Spouse: 16+ Dependent(s): Through age 25

Additional Plan Details

Time Period for Initial Care	90 days
Pre-Existing Condition Limitation[1]	12/12
Maternity	Included
Mental/Nervous & Substance Abuse	Excluded
Spouse Coverage	100%
Dependent Coverage	100%

Benefit	Benefit Amount/Day	Max Days/Per Year
CONFINEMENT		
Hospital Admission[2]	$1,500	1 day
Hospital Confinement	$100	31 days
ICU Admission	$3,000	1 day
ICU Confinement	$150	15 days
BOOSTERS & MISCELLANEOUS BENEFITS		
Health Screening Individual Limit: 1 visit per year, Family Limit: 6 visits per year	$50	

[1] This policy is guaranteed issue, but does contain a Pre-Existing Condition Limitation. Please refer to the certificate for more information on exclusions and limitations, such as Pre-Existing Conditions.

[2] Hospital does not include: convalescent homes, or convalescent, rest or nursing facilities; facilities affording primarily custodial, educational or rehabilitory care; or facilities primarily for care of the aged/elderly, persons with substance abuse issues/ disorders or mental/nervous disorders. Confinement means the assignment to a bed in a medical facility for a period of at least 24 consecutive hours. Required hours may vary by state.

Additional Benefits

Will Preparation and Planning

Help protect your and your family's financial future. This simple, online Will preparation tool helps you create a customized Will built around your state-specific laws. You can also create other legal documents, like a living Will and power or attorney document. It's easy, safe and secure. Get prepared at www.guidanceresources.com.

Identity Theft

Use our online tips and prevention kit to help stop identity theft before it happens. If someone steals your identity, we can help. Just call our personal case managers for step-by-step assistance. Real-time support is available anytime, from anywhere in the world. For help, please call (800) 344-9752 or visit www.guidanceresources.com and use the Web ID: NYLGBS.

Confidential Employee Assistance Plan

The Employee Assistance Plan (EAP) can assist you during challenging times when you need a little extra help. Whether the issues are big or small, the EAP support program is available to help you and your family find a solution to restore peace of mind. All employees have free, confidential access to a program that offers support, guidance and resources.

- Child and senior care issues
- Relationships
- Workplace Conflicts
- Stress, anxiety and depression
- Life improvement and personal achievement
- Legal and financial consultation
- 100% CONFIDENTIAL

You and your household members have access to three face-to-face sessions with a behavioral counselor. Access New York Life's EAP Program 24 hours a day, 7 days a week by calling (800) 344-9752 or by going online at www.guidanceresources.com, using Web ID: NYLGBS.

Pet Insurance

As a Team Select employee, you're eligible for preferred pricing on coverage for your pets through ASPCA pet insurance. For more information, contact ASPCA at (877) 343-5314 or visit www.aspcapetinsurance.com/teamselect; enter discount code: PET18TSHC.

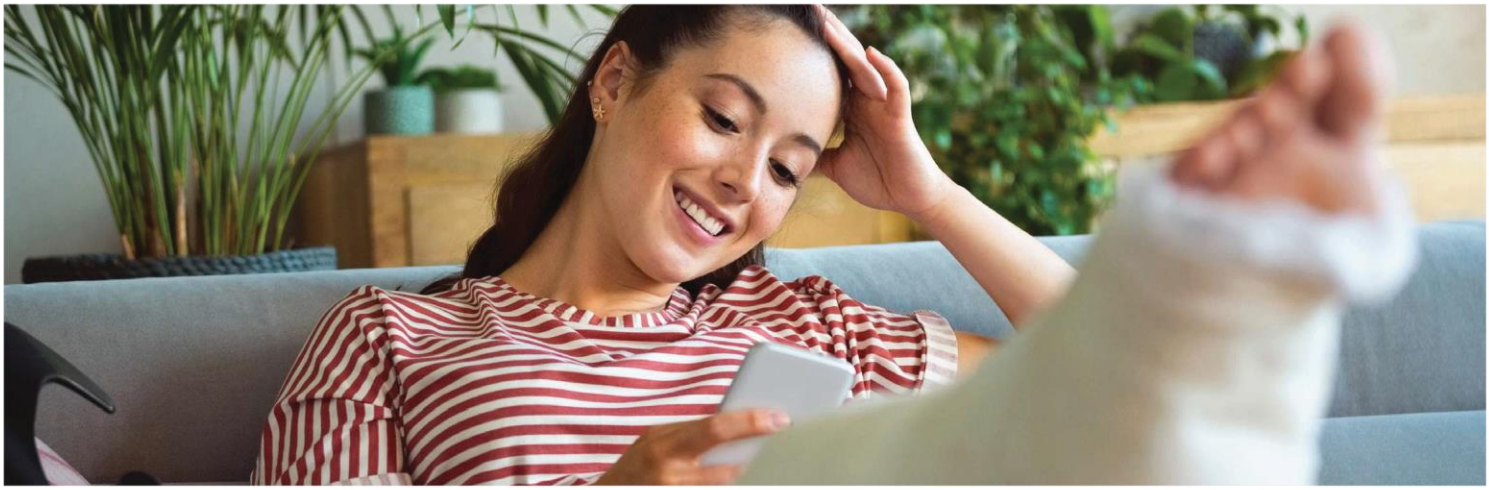
Coverage includes accidents, illnesses, cancer, hereditary conditions, behavioral issues and more You can also add preventive care. This benefit is a discount program; you pay ASPCA directly.

Available to all employees and members of their household, including children up to age 26.

Whatever life throws at you throw it our way.

Employee Assistance & Wellness Support.

Life: just when you think you've got it figured out, along comes a challenge. Whether your needs are big or small, New York Life Group Benefit Solutions is there for you with our Employee Assistance & Wellness Support program[1]. It can help you and your family find solutions and restore your peace of mind. This is just another example of how we are committed to Putting Benefits To Work For People℠.



Our suite of value-add resources includes:

› Employee Assistance Program[1]

Are you feeling overwhelmed by the demands of balancing work and family life? Maybe you have questions about a legal or financial concern. You and your family members now have access to various counseling services including legal, financial, and work-life balance assistance. All counseling calls are answered by a Master's or PhD-level counselor who will collect some general information and will discuss your needs. The Employee Assistance Program provides a maximum of three sessions, per issue, per year.

› GuidanceResources®[1]

When you need information quickly to help handle life's challenges, you can visit guidanceresources.com for resources and tools on topics such as health and wellness, legal regulations, family and relationships, work and education, money and investments, and home and auto. You will also have access to articles, podcasts, videos, slideshows, on-demand trainings and "Ask the Expert" which provides personal responses to your questions.

› Well-being Coaching[1]

Sometimes you may need help with personal challenges and physical issues that can be overwhelming. To help you achieve your goals, you will have access to a certified coach who will work with you, one on one, to address health and well-being issues such as burnout, time management and coping with stress. You have access to five sessions per year. All sessions are conducted telephonically.

See additional information on next page ›

FamilySource®[1]

Managing the everyday concerns of home, work and family can be difficult. To help resolve those concerns, you have access to family care service specialists that provide customized research, educational materials and prescreened referrals for childcare, adoption, elder care, education, and pet care.

Contact Info:

Employee Assistance and Wellness Support 24/7

Phone: (800) 344-9752

Website: guidanceresources.com
Web ID: NYLGBS

1. These programs are NOT insurance and do not provide reimbursement for financial losses. Some restrictions may apply. These services are provided exclusively by ComPsych® Corporation. Customers are required to pay the entire discounted charge for any discounted products or services available through these programs. Some services are available at the option of the employer for an additional cost. Programs are provided through third party vendors who are solely responsible for their products and services. Full terms, conditions and exclusions are contained in the applicable client program description and are subject to change. Program availability may vary by plan type and location and are not available where prohibited by law. These programs are not available under policies issued by New York Life Group Insurance Company of NY.

FamilySource and GuidanceResources are registered trademarks of ComPsych Corporation.

All programs are effective for the member/participant on the first day of coverage.

New York Life Group Benefit Solutions products and services are provided by Life Insurance Company of North America or New York Life Group Insurance Company of NY, subsidiaries of New York Life Insurance Company.

Life Insurance Company of North America is not authorized in NY and does not conduct business in NY.

New York Life Insurance Company
51 Madison Avenue
New York, NY 10010

123741 0822 SMRU 1951110 Exp. Date 09.08.2024

Conflicts with Plan Documentation

This Benefit Guide is designed to provide basic information regarding employee benefit plans and programs available to eligible employees of Team Select Home Care [and its subsidiaries]. It does not detail all of the terms, conditions, restrictions, and exclusions contained in the plan documents, carrier contracts or the Summary Plan Descriptions (SPDs) for the various benefit plans and programs. This overview merely summarizes the employee benefit plans and programs and does not create any contractual rights for any current or former employee or any other individual. The benefit provisions of the applicable plan document, contract or SPD will govern the determination of any individual's rights under any employee benefit plan or program. This document does not constitute a plan document or SPD as defined by the Employment Retirement Income Security Act of 1974, as amended (ERISA). Team Select Home Care [and its subsidiaries] reserve the right to amend or terminate any of its employee benefit plans and programs at any time and without notice or cause.

Annual Notices

Employees can access these notices on your HRIS platform. You may also request a printed copy of the required notices by contacting Human Resources.

IMPORTANT: *Our benefit package is designed under "Section 125" of the IRS Code. This allows you to take advantage of federal and state laws by purchasing some of your benefits with pre-tax dollars. Under Section 125, any required contributions for medical, dental, vision, HSA, and FSA will be made with pre-tax dollars.*

REMINDER: *You may only change your pre-tax benefit elections once per year, during open enrollment, unless you experience a qualified "change in status."*